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ABSTRACT

This article describes a unique health care delivery system, the Mental Health of the Rural Elderly Outreach Program. The project in designed to identify and provide mental health services to an underserved population, the rural elderly, who are suffering from severe and disabling mental illness. Delivery of mental health services to the rural elderly is described as a statewide priority in Iowa, with the need for such services enhanced by the current farm crisis. The project described relies on the cooperation and support of both public and private entities and integrates a variety of health, mental health, and human service agencies in the planning and delivery of services to elderly persons with mental illness, as well as appropriate referrals for those in need of medical and social services. Five referral sources are identified and described: (1) psychosocial screening at local sites, such as congregate meals; (2) referrals through the county case management team and its associated agencies; (3) training of nontraditional referrals sources, known as Gatekeepers, such as rural mail carriers, to locate and refer high-risk elderly; (4) mental health outreach specialists who serve as liaisons between the elderly outreach program and elderly service agencies; and (5) contact with discharge planning departments of mental health and health care institutions. Assessment, treatment, referral process, and preliminary outcomes are discussed. (Author/NB)

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OUTREACH PROGRAM: A UNIQUE HEALTH CARE DELIVERY SYSTEM

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MENTAL HEALTH OF THE RURAL ELDERLY

OUTREACH PROGRAM: A UNIQUE HEALTH CARE DELIVERY SYSTEM

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ABSTRACT

This article describes a unique health care delivery system, the Mental Health of the Rural Elderly Outreach Program. The project is designed to identify and provide mental health services to an underserved population, the rural elderly, who are suffering from severe and disabling mental illnesses. Delivery of mental health services to the rural elderly is a statewide priority, with the need for such services enhanced by the current farm crisis. The project described relies on the cooperation and support of both public and private entities and integrates a variety of health, mental health, and human service agencies in the planning and delivery of services to elderly persons with mental illness as well as appropriate referrals for those in need of medical and social services. Five referral sources are identified and described, and the assessment, treatment, referral process, and preliminary outcomes are discussed.

Introduction and Project Overview

Iowa has had dramatic increases in the number of elderly persons in its rural areas over the past decade. Elderly mental health service needs have been a priority of the State mental health authority for the past two years. However, several barriers have impeded the effective delivery of services, i.e., inadequate number of staff knowledgeable in psychogeriatrics, limited service delivery models for elderly in rural areas, and lack of coordination among human services, mental health, medical, and aging service providers. In an effort to overcome these barriers and to clearly identify the mental health needs of the rural elderly, the Abbe Center for Community Mental Health (ACCMH), in cooperation with the Heritage Agency on Aging, developed a model outreach program to identify and deliver outpatient mental health services to the rural elderly with serious and persistent mental disorders. Data from Linn County's Long Range Planning Task Force estimated that 20 percent of the elderly in rural Linn and Jones Counties (the catchment area served by the ACCMH) were in need of mental health services but were not receiving them.

In this rural elderly outreach program (EOP), persons in need of mental health, medical, and social services are identifed through a unique combination of five approaches: 1) psychosocial screening at local sites, such as congregate meals; 2) referrals through the county case management team and its associated agencies; 3) training of non-traditional referral sources, known as "Gatekeepers," such as rural mail carriers, to locate and refer high-risk elderly; 4) mental health outreach specialists who serve as

liaisons between the EOP and elderly service agencies; and 5) contact with discharge planning departments of mental health and health care institutions. The outreach model is illustrated in Figure 1.

Following referral, a multi-disciplinary outreach team conducts comprehensive in-home mental health evaluations, implements and coordinates an appropriate treatment plan, including referrals to medical and social service agencies. Services are provided to mentally impaired elderly either through existing service delivery mechanisms or home-based care. The referral sources and process are described in more detail later in this article.

A multi-faceted evaluation of model program is on-going. Program efficacy is being analyzed in terms of: 1) ability to identify rural elderly who are in need of services; 2) effectiveness of the mental health services in alleviating symptomatology and improving functioning; and 3) cost-effectiveness of the program. This independent evaluation is conducted by the Center for Health Services Research (CHSR) at the University of Iowa.

Need for the Rural Elderly Outreach Program

The panel on rural mental health of the President's Commission on Mental Health contended that the rural elderly population is vastly underserved by the mental health system. (President's Commission on Mental Health, 1978). The panel emphasized that rural areas have unique mental health service needs:

> Rural communities tend to be characterized by higher than average rates of psychiatric disorders, particularly depression, by severe intergenerational conflicts, by an exodus of individuals who might

> serve as effective role models for coping, by an acceptance of fatalistic attitudes and minimal subscription to the idea that change is possible (page 1164).

Despite the clear need for services, the rural elderly only account for between 4-6 percent of community mental health center (CMHC) patients nationally and less than 2 percent of the caseload of private psychiatrists. Review of the National Institute of Mental Health (NIMH) Inventory of CMHCs reveals a -.20 correlation between the ratio of rural elderly clients to total clients and further that the CMHCs in rural areas serve proportionately fewer elderly than CMHCs in more urban areas (National Institute of Mental Health, 1977).

Scheidt and Windley (1982) found that only 1 percent of small-town elderly used mental health services, whereas between 12-23 percent were "at risk" for mental disorders. Other epidemiological studies have similarly estimated that up to 25 percent of the elderly have significant mental health problems (Rosen, Coppage, Troglin, and Rose, 1981). In general, elderly ex-patients as well as non-institutionalized community elders have a need for community treatment that is not adequately addressed (Butler and Lewis, 1982).

Within Iowa, the statistics are even more alarming. Since Fiscal Year 1982, admissions to the Geriatric/Medical Units at the four state mental health institutes have dropped nearly 83 percent. However, this decline is not indicative of decreased utilization, but rather a dramatic increase in the lengths of stay for treatment which precludes new admissions. Iowans admitted to the Mental Health Institutes are growing older and experiencing more debilitating mental and physiological problems that increases the

difficulty of providing services in the rural community. Further, the remainder of elderly persons in need of mental health services are not being served by community-based providers. Although the NIMH State Mental Health Program Indicators-1983 indicated that slightly more than 7,000 elderly Iowans were provided with outpatient services, this represents only 1.9 percent of the state's elderly population. Furthermore, if the seven most heavily populated counties were removed from this data, utilization rates would be even smaller. Clearly, there is a need to reach a greater percentage of the rural elderly in order to identify and attract those persons in need of mental health services. Effective mental health service delivery in rural America requires innovative approaches, which includes coordination and cooperation among mental health, medical, and social service providers. A more appropriate rural mental health delivery system must maximize limited resources, address community needs, provide continuity of care, and use professional, paraprofessional, and lay personnel appropriately (Palmer and Cunningham, 1983).

The limited medical and social resources in many rural areas increase the likelihood that correctable illnesses and sensory deficiencies will remain undetected and untreated. Because there are few mental health services available in rural America and rural Americans are reluctant to accept such services even where they are available, care alternatives are often restricted to crisis intervention or long-term institutionalization. More often than not, people remain uncared for at home.

These problems can only be expected to proliferate as the number of rural elderly increase and those individuals experience life changes known to precipitate mental health problems. Geographic and cost factors

associated with the accessibility of services plus cultural norms and the stigma of mental illness make delivery of mental health services in rural settings problematic.

Problems in the delivery of services to the rural elderly in Iowa are currently exacerbated by the farm crisis. In recent testimony before the Joint Economic Committee of Congress, Heffernan (1985) identified depression as the primary stress reaction of rural families and communities to the farm crisis. Based on this sociological study, Heffernan recommended the development and funding of mental health outreach programs as an important approach to counteracting stresses associated with the farm crisis.

Outreach programs have been suggested as one effective approach in delivering services to the rural elderly, because those most at risk do not present themselves to mental health and social service agencies (Toseland, Decker, and Bliesner, 1979). Such a program would teach professionals and non-professionals both in medical and social services agencies and in the general public how to identify elderly who may need mental health services and how to refer these people to a special outreach team for assistance. An outreach team consisting of a psychiatrist, social worker, and nurse can overcome some of the limitations of rural mental health services by providing coordinated assessment, treatment, and aftercare of the rural elderly in their own homes (Lazarus and Weinberg, 1979). Outreach can provide diagnosis and treatment for homebound rural elderly who have physical limitations, major psychiatric illnesses (e.g., dementia, schizophrenia, paranoia, affective disorders), who are socially isolated, or who are experiencing a combination of problems.

Outreach approaches have proved helpful in treating urban elderly

patients who might not otherwise enter mental health programs until a crisis necessitates hospitalization (Wasson, Ripeckyj, Lazarus, Kupferer, Barry, and Force, 1984). In general, evaluations of these urban outreach efforts suggest that they provide rapid and effective mental health assessment and treatment, and minimize disruptions due to premature institutionalization of elderly patients (Kahn and Tobin, 1981; Raskind, Alvarez, Petrzyk, Westerlund, and Herlin, 1976; Reifler, Kethley, O'Neill, Hanley, Lewis, and Stenchever, 1982).

However, the effectiveness of these programs in providing a viable alternative to hospitalization and long-term institutionalization for the rural elderly has not been tested. Service providers must understand and be sensitive to the rural value system and social ecology of the area. Otherwise, mental health workers may find themselves addressing assumed rather than real needs. Borrowing successful urban techniques, such as outreach programs, and imposing them without modification in rural settings may not be appropriate or effective.

The EOP described in this article is designed to identify rural elderly individuals who are in need of mental health care, to deliver needed services, and to initiate and coordinate referrals to the appropriate medical and social services agencies. It addresses the problem of inadequate mental health services and inappropriate hospitalization by taking services to the people most in need of them--the rural elderly. It also addresses another service delivery problem common in rural areas, the sparse concentration of mental health professionals available to identify and treat the rural elderly.

Overview of Referral Sources

The ACCMH coordinates the identification and referral process with the assistance of the Heritage Agency on Aging and the Linn County Case Management Team.

Referral Source I. [Refer to Figure 1.] The first approach to identifying rural elderly in need of mental health services is to screen the elderly at local sites. Nurses have been trained to use an easy to administer battery of psychosocial assessment tools that can be completed in less than 30 minutes, including the (1) Short Portable Mental Status Questionnaire; (2) Geriatric Depression Rating Scale (GDRS); and (3) Short Psychiatric Evaluation Schedule. Each of these tools have been used often to assess elderly people and are meant to be used with general populations to distinguish impaired persons from non-impaired. The nurse is introduced to elderly persons at sites including Visiting Nurse Association well elderly clinics, church related activities, and congregate meals.

Referral Source II. There is an established interagency network called the Linn County Case Management Team. This team includes the Linn County Health Center, Hawkeye Area Community Action Program, Heritage Agency on Aging, Family Service Agency, Area Substance Abuse Council, Family Practice Center, and the Department of Human Services. Informational sessions have been held for each of these health care and social services agencies to explain the rural elderly outreach project and to foster coordination of services to the rural elderly with mental health needs. The EOP team social worker serves as the liaison to the Case Management network and meets with them twice a month to discuss rural elderly clients with mental health problems who are in need of multiple services.

Referral Source III. Non-traditional referral sources, known as "gatekeepers" have been used to identify the rural elderly in need of mental health services. Gatekeepers in this context are people who reside or work in the rural community and, in the course of their regular activities, come into contact with the rural elderly. They are called gatekeepers because they "open the gates" between isolated older people and sources of needed help.

To explain the gatekeeper's approach to outreach, it is contrasted with more traditional methods (Lidoff, 1984). Generally, outreach has involved either or both of the following:

1. Vigorous public information efforts, conveying the message: If you come to us, we can help you.
2. Sending paid or volunteer workers out to look for potential clients, conveying: The community has given us resources and we want to use them to deal with your problem.

These traditional methods have succeeded in locating many people who need help in filling the caseloads of most service programs. But such methods may overlook people who are not sufficiently able to request help for themselves or whose isolation or resistance makes them difficult to find in rural ares.

The gatekeeper approach works differently and conveys a different message. It organizes the fabric of the rural community itself and brings forth the people who most need help, and it assumes that both the agency and community are problem-solving partners. Although many agencies are aware of and work with individual gatekeepers, the approach described in this model

is more comprehensive, and closely integrated into a total system for identifying and responding to rural older people's needs. Elderly persons identified by gatekeepers tend to be the most dysfunctional and disadvantaged. They are quite old, often suffer from dementia and depression, and lack family support. In addition, they have bio-medical problems which complicate their health status and are often resistive to offers of treatment (Lidoff, 1984).

Gatekeepers are not asked to be case workers or counselors or to do anything in addition to their ordinary activities. Instead, they are asked to be alert to signs that an older person may be ill or in trouble. If indications of a problem become apparent, they are instructed to phone the ACCMH. Most commonly, gatekeepers do not regard the role as an imposition but as a way to help their fellow citizen who may be in trouble. They see the problems in any case; the outreach model program simply gives them a constructive way to react. The gatekeepers themselves gain certain benefits, too. For participating companies and agencies, their involvement is good public relations, enhancing their images (Lidoff, 1984).

Gatekeepers are non-professionals who have contact with the rural elderly or may be able to provide information about them. Gatekeepers include, for example, rural mail carriers, veterinarians, the sheriff's department, extension service workers, utility workers, and farm implement and grain dealers. These rural neighbors have in most cases enjoyed lifelong contact with the elderly person and may therefore be more sensitive to changes in personality and habit indicative of mental illness. These persons also have more direct knowledge of existing social support networks and consequent social isolation.

Thus far the EOP has trained more than 200 rural gatekeepers to locate, identify, and follow high-risk elderly who would not self-refer or who are without family or friends to act on their behalf. This approach modifies elements of the successful Spokane Community Mental Health Program where Raschko (1985) reported that gatekeepers account for about one out of every three admissions to the in-home case management program at the Spokane Community Mental Health Center.

Referral IV. Four half time Mental Health Outreach Specialists (2 nurses and 2 social workers) with educational background and experience working with elderly clients have been assigned to four community-based agencies serving the rural elderly: Visiting Nurse Association, Hawkeye Area Community Action Program, Council on Aging, and Human Resource Management. These Outreach Specialists (1) identify and recruit community gatekeepers; (2) conduct gatekeeper training sessions; (3) engage in outreach and case finding for clients needing mental health services; (4) provide mental health assessments and appropriate referrals to the EOP team; (5) serve as a mental health resource agency staff and assist staff to increase their knowledge and case planning skills in the mental health area; and (6) collaborate with EOP team members to provide educational and staff development programs in mental health areas and conduct inservice programs in their assigned agencies and the rural community at large. Each Outreach Specialist is supervised by a member of the EOP team and meets weekly with their supervisor to discuss referrals and assessment services.

Referral Source V. The EOP team Social Worker has systematically met with discharge planners in all hopsitals and inpatient health facilities serving the Linn and Jones County Catchment area. These informational

sessions are designed to heighten awareness of the EOP and thus enhance aftercare referrals to the EOP team whenever an elderly patient is discharged to the communities served by the project. Those rural elderly under the care of a private psychiatrist or who are being discharged to an institutional setting (e.g. nursing home) are generally not referred to the outreach project unless a request is received from the attending physician.

Criteria for Referral

To be considered for assessment and treatment by the elderly outreach team, persons must be over 55, reside in the mental health catchment area, and be non-institutionalized. Persons in nursing homes are eligible for referral and evaluation only if they have potential for outplacement in the community. Gatekeepers, using knowledge of the signs and symptoms of mental illness in the elderly, are encouraged to make referrals for evaluation whenever they suspect an emotional problem. For example, the rural mail carrier might notice untouched mail, or the meter reader or utility worker who enters the home might observe the shades drawn and lights dimmed or be accused of "spying for the government." In rural settings an elderly, confused person wandering down a country lane or into a cornfield might not be noticed as easily as a disoriented elder in an urban setting, who is more likely to come to the attention of passing motorists, police, etc. The need for vigilant neighbors is thus even more pressing in the geographically and socially isolated areas of rural America. Similarly, members of the case management network are encouraged to refer elderly clients for evaluation whenever they suspect a problem. For example, the Meals-On-Wheels delivery man might notice untouched food suggestive of depression, or the homemaker

or home health aide might notice signs of personal and environmental neglect, sometimes indicating disturbed thinking of skizophrenia or dementia.

Assessment and Treatment

Rural elderly persons identified as potentially at risk for mental health problems by any of the five identification mechanisms (i.e., on-site screening, case management network, gatekeepers, mental health Outreach Specialists, discharge planning departments) are referred to the EOP at the ACCMH. The EOP team, composed of a part-time psychiatrist, geropsychiatric nurse, and social worker, approaches each referred person from a holistic perspective. They conduct an in-home comprehensive mental health assessment and evaluate the elderly individual's environment, social support network, economic status, and possible precipitating events (such as recent farm foreclosure). The assessment also systematically evaluates functional capacity for self-care and sound interpersonal relationships, as well as ability to remain in the rural community. The elderly person's physical health status is also assessed by the team psychiatrist, as concommitant physical illnesses are often present in the disturbed elderly which can exacerbate or predispose to mental health problems. Frequently, referrals for laboratory work and comprehensive medical evaluations are made to local family practitioners or the Geriatric Assessment Clinic at the University of Iowa.

EOP team members meet weekly to discuss all newly assessed patients and those continuing on their caseload. The purposes of the team meetings are to (1) develop a coordinated treatment plan for each patient with a

psychiatric diagnosis; (2) assign primary responsibility for case management to one outreach team member; (3) systematically assess patient progress and evaluate the treatment plan on an on-going basis; and (4) determine appropriate "discharge" from the active treatment model and coordinate referrals for inpatient care or continued community support for both patients and their families.

EOP Accomplishments: First Six Months of the Project

Since referrals to the EOP began in october of 1986, the following goals have been accomplished:

1) 175% increase in number of rural elderly identified in need of services.
2) 125 in-home evaluations conducted.
3) 70 previously untreated rural elderly enrolled in a treatment program.
4) 10 elderly clients received aftercare services.
5) 85 referrals made to social service or medical agencies.
6) Improved depression, psychiatric symptoms and ability to do ADLs in 54 clients. No change in status of 11 clients (with dementia primarily) and 5 clients' conditions deteriorated, as measured by psychosocial and clinical tests.
7) Widespread referral network established through case management and gatekeeper training efforts, and use of Outreach Specialists. 200 gatekeepers have been trained so far.

8) 39% decrease in number of rural elderly from Linn and Jones Counties admitted to State mental institutes. Evaluation by the CHSR is not yet complete.

Conclusion

This article has described a unique health care delivery system designed to identify and provide mental health services to an underserved population, the rural elderly, who are suffering from severe and disabling mental illnesses. Preliminary data suggest the program is effective and that it can be replicated in rural areas throughout Iowa and the United States, resulting in system changes that will improve the mental health and quality of life of a most underserved population, the rural aged. In Iowa, delivery of mental health services to the rural elderly is a state-wide priority, with the needs for such services enhanced by the current farm crisis. The rural elderly outreach effort relies on the cooperation and support of both public and private entities, and integrates a variety of medical, mental health, and human services agencies in the planning and delivery of services to rural elderly persons with long-term, severe, disabling mental illness.

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FIGURE 1

RURAL OUTREACH MODEL